calgary RETINA CONSULTANTS

Southern Alberta Eye Center

PATIENT INFORMATION

Please answer all questions and sign the front and back pages

Patient legal name: _____ _____ _____
(last) (first) (middle)

Sex: male/female/_____ **Date of birth:** day _____ month _____ year _____

Health care #: _____ **Province:** _____
Is this a Workers Compensation claim (WCB)?: yes no

Home address: _____
City: _____ **Province:** _____ **Postal code:** _____
Home phone: ( ) _____-_____ **Cell phone:** ( ) _____-_____
Work phone: ( ) _____-_____ **Email:** _____

Occupation: _____ **Employer:** _____

Emergency contact name: _____
Relationship: _____ **Phone #** (different than above): _____

Referring doctor (first and last name & location) or **none**: _____
Family doctor (first and last name & location) or **none**: _____
Optometrist (first and last name & location) or **none**: _____

Current medical conditions and medications (circle all conditions that apply or **none**):

high blood pressure	diabetes Type 1 Type 2	kidney disease	rheumatoid arthritis
high cholesterol	cancer (type)	lung disease	osteoarthritis
heart disease	thyroid disease	asthma COPD	**smoking**: (circle one)
Pentosan Polysulfate	Elmiron	Plaquenil	never current former

Prior medical history (circle all that apply or **none**):

stroke (year)	heart attack (year)	cancer (type)	kidney failure (year)

Other medical conditions (please list or **none**): _____

_____

Medications and supplements (please list all or provide list or **none**): _____

_____

Surgical history (please list **all surgeries** or **none**): _____

Allergies (please list or **none**): _____

I verify that the above information is true and accurate to the best of my knowledge:

Signature: _____ **Printed name:** _____
(patient or legal representative, if applicable or if patient is under 18)

Date: _____

CONTINUED ON PAGE 2 – please turn over

Please be aware that your picture will be taken for identification purposes, it will be kept strictly confidential in your chart.

Calgary Retina Consultants (CRC) are strongly committed to clinical vision research to further advance knowledge and treatment of eye disease in their patients. One method of research is to review patients' medical records by ophthalmologists and associated staff in order to:

- identify patients who might be eligible to participate in a given study approved by a research ethics committee (prospective studies) and
- identify patients and document findings for answering a given research question (retrospective studies).

Results from prospective and retrospective studies could be presented at research conferences and/or published in scientific medical journals with assurance that no personal identities (name, address, date of birth, Alberta Health Care number) will be disclosed.

To achieve this, we need your authorization to review your medical records:
Please complete the following section.

I, _____, (print your name)

☐ authorize ☐ refuse (check one) the CRC Physicians, their designates, and staff to review my medical records for prospective and retrospective studies. This consent is valid for the duration of my care as a patient at this practice unless I revoke my consent.

Sign: _____ Date: _____

Authorization to access your Alberta Netcare record, as needed:

Sign: _____ Date: _____

Authorization to release/receive your medical information to/from another physician for continuity of patient care:

☐ **authorize** ☐ **refuse** *(check one)*

Sign: _____ Date: _____

Revised Nov 2023